Montana Medicaid
Provider Enrollment Application

Please type or block print the requested information as completely as possible. If any field is not applicable, please enter N/A. If you need extra space to answer any question, please attach an additional page. An incomplete form may delay the approval of this application. Please direct questions to the ACS Provider Relations Unit at (800) 624-3958 (Montana) or (406) 442-1837 (Helena and out-of-state).

For Fiscal Agent Use Only	
ACS Assigned Provider Number	**Approval Date**
_____	_____

IMPORTANT: PLEASE READ INSTRUCTIONS ABOVE QUESTIONS COMPLETELY BEFORE PROCEEDING

1. Enter your **business or provider name** and address below. **(Physical address is required.)**

_____
Name

_____
Address

_____
City State Zip

2. Enter your **practice telephone** and fax number.

(_____) _____ - _____

(_____) _____ - _____ (Fax)

3. Enter your two-digit **County Location Code.** Refer to *Table 1a or 1b* included in this enrollment application.

_____/_____

4. **Pay to:** If you wish to direct your Remittance Advice to an address other than your practice address, enter that information here.

Pay to Address: _____

_____

_____

Correspondence: If you wish to have all Medicaid related correspondence sent to an address other than your practice address, enter that information here. **Please note that ACS can only store two provider addresses. Example: If your correspondence address is different than your payment or practice address, we cannot cross-reference the third address.**

Correspondence Address: _____

_____

_____

For Hospitals Only: Before payment can be made to your hospital for services provided to Montana Medicaid recipients, the name and address of your Medicare intermediary **must** be provided.

Medicare Intermediary Address: _____

_____

_____

5. Enter your most current **Professional License Number**, state where issued, effective date and expiration date in MMDDYY format. The provider type indicated in Question 4 will determine which certification/license requirements must accompany your enrollment. Please refer to *Table 4*. **(ATTACH A COPY OF YOUR LICENSE.)**

License Number	State	Effective Date	Expiration Date
_____	_____	_____/_____/_____	_____/_____/_____

6. Enter your two-digit **Provider Type Code**. Refer to *Table 2* included in this enrollment application. _____/_____

7. Enter the two-digit **specialty code, board certified information, certification date in MMDDYY format, and certification number.** Refer to *Table 3* included in this enrollment application.

   Specialty Code: _____ Board Certified (Yes/No): _____

   Certification Date: _____ Certification Number: _____

8. Enter your one-digit **Type of Ownership Code**. Refer to the following *table* for codes. _____

0 –Other	2 – Partnership	4 – Hospital Based	6 – Group
1 – Individual	3 – Corporation	5 – HMO	7 – Clinic

9. Enter the **Federal Identification Number of the business OR the Social Security Number** of the individual for which this application is being filed. Use the number you wish all income to be reported for Federal 1099 purposes and match the information indicated on your W-9.

   FEIN _____ or SSN _____

10. Enter your **Drug Enforcement Agency (DEA) number**. If you do not have a DEA number, enter N/A in this space. If you are a physician, you **must** enter this information. _____

11. Enter your **fiscal year end month:** _____

12. If you bill laboratory services, you must enter your ten-digit **Clinical Laboratory Improvement Amendments (CLIA) number,** CLIA type, and effective and termination dates in MMDDYY format. CLIA type values are listed below.

1 Registration	2 Regular Certificate	3 Accreditation
4 Wavier	5 Microscopy	6 Partial Accreditation

CLIA Number	CLIA Type	Effective Date	Termination Date
_____	_____	_____/_____/_____	_____/_____/_____

13. **For Pharmacies Only:** Enter your **National Association of Boards of Pharmacy (NABP) number.** _____
    If you are a pharmacy that has purchased another pharmacy, do you wish to keep the same dispensing fee? ☐ No ☐ Yes

14. **For oxygen and PASSPORT providers only:** Enter your **24-hour access telephone number:** (_____) _____ - _____

15. If you have previously billed Montana Medicaid, indicate the provider number you used: _____

16. Have you already provided services to a Montana Medicaid recipient? ☐ No ☐ Yes

    If yes, enter the earliest date of service. _____ **Attach a copy of your license to cover this time period.**

17. If you are enrolled in the Medicare program, enter the **Unique Physician Identification Number (UPIN)** assigned to you:

    _____

18. If you enrolled as a Medicare provider, enter your **Medicare number** if you wish to have your claims automatically transferred from Medicare to Medicaid: _____

19. If you have been assigned a **National Provider Identifier (NPI)** number, enter your NPI number: _____

20. **OWNERSHIP INFORMATION**

(Copy this page and complete for each person who has an ownership or control interest of 5% or more, OR is an agent or managing employee in this provider entity.)

A. Name (First, Middle, Last, Jr., Sr., MD, DO, etc.)	Date of Birth	
County/State/Country of Birth	Social Security Number	Montana Medicaid No.
Are you the spouse, parent, child, or sibling of other persons who have an ownership or control interest of 5% or more, OR an agent or managing employee in this provider entity? ☐ No ☐ Yes (If yes, give name of person and relationship.)		
Have you ever been sanctioned, debarred, suspended, excluded, or convicted of a criminal offense related to Medicare/Medicaid or any Federal agency or program: ☐ No ☐ Yes If yes, please explain:		
B. Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? ☐ No (Go to Section C.) ☐Yes (Fill in the following for each organization. Attach a copy of the organization's form IRS-P575 or, if not available, the W-9.)		
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
Organization Legal Business Name:	Employer ID No:	Medicaid ID No:
C. Parent/Joint Venture Information Is your organization a subsidiary company or joint venture? ☐ No ☐ Yes If yes, fill in the following information about your parent company/joint business.		
Legal Business Name:	Employer ID No:	Medicaid ID No:
Business Street Address Line 1		
Business Street Address Line 2		

City	County	State	Zip
Phone Number	Fax Number		

DEFINITIONS

Ownership interest means equity in the capital, the stock or the profits of the provider.

Person with an ownership or control interest means a person, partnership, corporation or other entity that (a) has an ownership interest totaling 5% or more; (b) has an indirect ownership interest equal to 5% or more; (c) has a combination of direct and indirect ownership interests equal to 5% or more; (d) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider if that interest equals at least 5% of the value of the property or assets of the provider; (e) is an officer or director of a provider that is organized as a corporation; or (f) is a general or limited partner in a provider that is organized as a partnership or limited partnership.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the provider or in an entity that has an indirect ownership interest in the provider.

21. **INDIVIDUAL ENROLLMENTS ONLY:** The U.S. Department of Health and Human Services, Office of Civil Rights is requesting the following information be completed for statistical purposes only. This information is optional and is not required for Montana Medicaid.

Gender: ☐ Male ☐ Female

Race: ☐ Asian or Asian American or Pacific Islander ☐ Hispanic ☐ White (not Hispanic) ☐ Black (not Hispanic) or African-American ☐ North American Indian or Alaska Native

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Printed Name of Person Filling out Form: _____ Date: _____

Signature of Person Filling Out Form: _____ Telephone #: _____

Provider Agreement and Signature

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. IN CONSIDERATION OF MEDICAID PAYMENTS MADE FOR APPROPRIATE MEDICALLY NECESSARY SERVICES RENDERED TO ELIGIBLE CLAIMANTS, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN, THE PROVIDER AGREES TO THE FOLLOWING:

The provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, including but not limited to policies contained in the Medicaid provider manuals, and the terms of this document.

The Provider certifies that the care, services and supplies for which the Provider bills Medicaid will have been previously furnished, the amounts listed will be due, and except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The Provider assures the Department that the Provider is an independent contractor providing services for the Department and that neither the Provider nor any of the Provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the Provider and the employment of all persons providing services under this enrollment form.

The Provider agrees to comply, as of December 1, 1991 and throughout the remaining term of this enrollment, with the applicable advance directive requirements of Section 1902(w) of the Social Security Act.

The Provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (4-88) which are applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. Copies of the form are available from the Department. The Provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The Provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer of employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The Provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794).

The Provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, martial status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or and any active connected with the provision of Medicaid services.

All hiring done in connection with the provision of Medicaid services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The Provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The Provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The Provider further agrees to, in accordance with relevant laws, regulations and policies, including the 1996 Department Policy on Confidentiality of Client Information, protect the confidentiality of any material and information concerning an applicant for or recipient of Medicaid services.

The Provider agrees to make and maintain records, as required by applicable laws, regulations, rules and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The Provider agrees to furnish on request to the Department, the United States Department of Health and Human Services, the Montana Medicaid Fraud Control Unit and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The Provider agrees to repay to the Department (1) the amount of any payment under the Medicaid program to which the Provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively the Department for the rate period.

The Provider agrees to notify ACS at the address stated below within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., Hospital, Swing Bed, Waiver, Home Health, etc.) for which Medicaid reimbursement is sought. I UNDERSTAND THAT PAYMENT OF CLAIMS WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAW.

Printed Name of Individual Practitioner:	
Signature of Individual Practitioner:	Date:

Or for facilities and non-practitioner organizations:

Printed Name of Authorized Representative	Title/Position:
Address:	Telephone Number:
Signature of Authorized Representative:	Date:

Please mail this completed enrollment form to:

ACS
Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604